Citation	Condition or Requirement

SECTION 1: ACCOUNTABLE CARE COLLABORATIVE PROGRAM

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Colorado enrolls Medicaid beneficiaries on a voluntary basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
_x_ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

_x_ i. fee for service;
____ ii. capitation;
_x_ iii. a case management fee;
_x_ iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____ vi. other. (Please provide a description below).

Citation	Condition or Requirement
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met *all* of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). __x__ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. __x__ ii. Incentives will be based upon specific activities and targets. __x__ iii. Incentives will be based upon a fixed period of time. __x__ iv. Incentives will not be renewed automatically. __x__ v. Incentives will be made available to both public and private PCCMs. __x__ vi. Incentives will not be conditioned on intergovernmental transfer agreements. ____ vii. Not applicable to this 1932 state plan amendment. **The following conditions apply to incentive payments for PCCMs in the Accountable Care Collaborative program:** **a. Incentives are based upon measures that are attributable to a reduction in utilization or costs, or improvement in health outcomes. The specific performance targets may change each year. The State determines the measurement areas, performance targets, and incentive amounts for the fiscal year (July-June), and communicates these to the PCCMs, no later than March 1 of each year.**

Citation	Condition or Requirement
	b. Prior to the start of each state fiscal year, the State determines the baseline against which performance is measured.
	c. The State pays any earned incentive payment to the PCCM on a quarterly basis within 180 days from the last day of the quarter in which the incentive payments was earned. The State calculates the incentive payment separately for each month in a quarter, and the PCCM may receive different amounts for each month within a quarter based on the specific performance targets the PCCM was able to meet during each specific month.
	d. The PCCM receives an incentive payment only for those targets the PCCM reaches in a given month. The PCCM does not have to pay PMPM moneys back to the State for adverse results.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* **In 2009, the Department hosted public forums to obtain input and advice about the ACC program. In addition, the Department established four ACC program advisory groups, including one that has representation from ACC members, families, advocates, PCCM providers, other Medicaid providers, the behavioral health community, and community organizations.**
1932(a)(1)(A)	5. The state plan program will___/will not_x_ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary_____ enrollment will be implemented in the following county/area(s): i. county/counties (mandatory) _____ ii. county/counties (voluntary)_____ iii. area/areas (mandatory)_____

Citation	Condition or Requirement

iv. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ___The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. _x_ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. _x_ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

1932(a)(1)(A
42 CFR 431.51
1905(a)(4)(C)

4. _x_ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)
42 CFR 438
42 CFR 438.50(c)(4)
1903(m)

5. _x_ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

1932(a)(1)(A)
42 CFR 438.6(c)
42 CFR 438.50(c)(6)

6. ___The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.

1932(a)(1)(A)
42 CFR 447.362
42 CFR 438.50(c)(6)

7. _x_ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.

Citation	Condition or Requirement
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. x The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8. x The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i) 1. List all eligible groups that will be enrolled on a mandatory basis.

None.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment in any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. x Recipients who are also eligible for Medicare.

Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. x Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian

Citation	Condition or Requirement
	Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act, or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. **Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.**
1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)	iii. _x_ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI. **Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.**
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. _x_ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act. **Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.**
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. _x_ Children under the age of 19 years who are in foster care or other out of-the-home placement. **Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.**
1932(a)(2)(A)(iv)	vi. _x_ Children under the age of 19 years who are receiving foster care or

Citation	Condition or Requirement
42 CFR 438.50(3)(iv)	adoption assistance under title IV-E. **Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.**
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. _x_ Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs. **Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.**
	E. Identification of Mandatory Exempt Groups
1932(a)(2) 42 CFR 438.50(d)	1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)* **Children who receive services through Colorado's Health Care Program for Children with Special Needs.**
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of title V children is determined by: ____i. program participation, ____ii. special health care needs, or _x_ iii. both
1932(a)(2) 42 CFR 438.50(d)	3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. _x_ i. yes

Citation		Condition or Requirement
		___ii. no
1932(a)(2) exempt 42 CFR 438.50 (d) *identification)*	4.	Describe how the state identifies the following groups of children who are from mandatory enrollment: *(Examples: eligibility database, self-*
		i. Children under 19 years of age who are eligible for SSI under title XVI; **Eligibility database.**
		ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; **Eligibility database.**
		iii. Children under 19 years of age who are in foster care or other out-of-home placement; **Eligibility database.**
		iv. Children under 19 years of age who are receiving foster care or adoption assistance. **Eligibility database.**
1932(a)(2) 42 CFR 438.50(d)	5.	Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* **Not applicable. Enrollment is not mandatory.**
1932(a)(2) 42 CFR 438.50(d)	6.	Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples. usage of aid codes in the eligibility system, self- identification)*

Citation	Condition or Requirement
42 CFR 438.50	i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient. ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: i. the existing provider-recipient relationship (as defined in H.1.i). **Clients enrolled in the ACC program have the option of selecting a Primary Care Medical Provider (PCMP), and may choose the primary care provider they already have a relationship with. If that provider is not part of the ACC program, the PCCM (Regional Care Coordination Organization) will request that the provider enroll. The State will initially assign a PCMP based on which provider was the main source of Medicaid care for the client during the previous year.** ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii). **The Regional Care Collaborative Organizations work with the State to recruit providers that have traditionally served Medicaid recipients to be a part of the ACC program. These providers have been involved as stakeholders since program planning began.** iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56

Citation	Condition or Requirement
	(d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)* **The State's enrollment process does not preserve the equitable distribution of Medicaid recipients among PCCMs because enrollment is voluntary. Clients may choose from among available MCOs and PCCMs in their geographic areas. A list of the available options is included in the enrollment letter and packet sent to Medicaid clients who are passively enrolled into the ACC program.**
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information: i. The state will_x_/will not___ use a lock-in for managed care. ii. The time frame for recipients to choose a health plan before being auto-assigned will be: **Clients are notified of the State's intent to enroll them into the program 30 days before they are enrolled. This letter also describes other options available, including managed care plans, the fee-for-service option, and any other available program.** iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)* **The State's enrollment broker sends the Medicaid client a letter notifying them of the State's intent to enroll them into the ACC program.** iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

Citation	Condition or Requirement

The letter sent by the State's enrollment broker to notify a client of the State's intent to enroll the client in the ACC program also includes instructions for disenrolling within the first 90 days of the client's enrollment into the program.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

Enrollment is based on geographic service areas. The ACC program enrolls clients receiving fee-for-service Medicaid and will not affect the number of clients passively enrolled into other managed care plans.

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

The state monitors rates of enrollment through monthly reports generated by the enrollment broker.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. x The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. x The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a

Citation	Condition or Requirement

choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ___ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

_x_ This provision is not applicable to this 1932 State Plan Amendment.

4. ___ The state limits enrollment into a single Health Insuring Organization (HIO), *if and only if the HIO is one of the entities described in section* 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

_x_ This provision is not applicable to this 1932 State Plan Amendment.

5. _x_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

___ This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will _x_ /will not___ use lock-in for managed care.

2. The lock-in will apply for _12_ months (up to 12 months).

3. Place a check mark to affirm state compliance.

_x_ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

a. If the temporary loss of eligibility has caused a client to miss the annual disenrollment opportunity, the client may disenroll upon regaining eligibility.

Citation	Condition or Requirement
	b. Enrollment into the PCCM program, or the choice of or assignment to the provider, was in error. **c. There is a lack of access to covered services within the program.** **d. There is a lack of access to providers experienced in dealing with *the client's health care needs.*** **e. Any other reasons satisfactory to the State.**
	K. Information requirements for beneficiaries Place a check mark to affirm state compliance.
1932(a)(5) 42 CFR 438.50 42 CFR 438.10	____The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.) **42 CFR 438.10(i) does not apply("Special rules: States with mandatory enrollment under state plan authority") because enrollment is voluntary under this plan.** **The State is in compliance with the informational requirements of 42 CFR 438.10(e) and 42 CRF 438.10(f) and other applicable requirements of 42 CFR 438.10.**
1932(a)(5)(D) 1905(t)	L. List all services that are excluded for each model (MCO & PCCM) **All Medicaid services are included in the ACC program.**
1932 (a)(1)(A)(ii)	M. Selective contracting under a 1932 state plan option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. The state will_X___/will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

Citation | Condition or Requirement

2. __X___ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)* The State limits the number of PCCM entities that serve as Regional Care Collaborative Organizations (RCCOs). To maximize collaboration, the program is designed to have one RCCO in each area of the state. RCCO selection was done as a competitive procurement. The criteria for selection are extensive, and are included in the Request for Proposals.

4. ___ The selective contracting provision in not applicable to this state plan.

N. PCCM Contracts

1. **PCCM contracts for Regional Care Collaborative Organizations and Primary Care Medical Providers set forth all payments (except for fee-for-service reimbursements) to these PCCMs, including the per-member-per-month fee and any incentive payments. These contracts also describe the services rendered in exchange for the payments.**

2. **The State shall *submit all* PCCM provider contracts to CMS for review and approval.**

Citation	Condition or Requirement

SECTION 2: PRIMARY CARE PHYSICIAN PROGRAM (PCPP)

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Colorado enrolls Medicaid beneficiaries on a voluntary basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

___ i. MCO
_x_ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
___ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

_x_ i. fee for service;
___ ii. capitation;
___ iii. a case management fee;
___ iv. a bonus/incentive payment;
___ v. a supplemental payment, or
___ vi. other. (Please provide a description below).

Citation	Condition or Requirement
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met *all* of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). ____i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. ____ii. Incentives will be based upon specific activities and targets. ____iii. Incentives will be based upon a fixed period of time. ____iv. Incentives will not be renewed automatically. ____v. Incentives will be made available to both public and private PCCMs. ____vi. Incentives will not be conditioned on intergovernmental transfer agreements. _x_vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* **The initial implementation of the program was through a waiver in 1984. The program was initiated with participatory policymaking through multiple formal and informal venues soliciting input from stakeholders and community groups including: the Disability Medicaid Advisory**

Citation	Condition or Requirement
	Committees, Disability Working Group and the Managed Care Consumer *Advisory Committee.* In 2007-08, the State brought together working groups of providers, clients and other stakeholders to help redesign all of managed care.
1932(a)(1)(A)	5. The state plan program will___/will not_x_ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary____ enrollment will be implemented in the following county/area(s): i. county/counties (mandatory) _____ ii. county/counties (voluntary)_____ iii. area/areas (mandatory)_____ iv. area/areas (voluntary)_____
	C. State Assurances and Compliance with the Statute and Regulations. If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. ____The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. _x__The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A)	3. _x__The state assures that all the applicable requirements of section 1932

Citation		Condition or Requirement
42 CFR 438.50(c)(3)		(including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4.	_x_ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5.	_x_ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6.	____ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7.	_x_ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8.	_x_ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis.

The Primary Care Physician Program is voluntary. No eligible groups will be enrolled on a mandatory basis.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

Citation		Condition or Requirement
1932(a)(2)(B) 42 CFR 438(d)(1)	i.	_x_ Recipients who are also eligible for Medicare. If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*
1932(a)(2)(C) when 42 CFR 438(d)(2)	ii.	_x_ Indians who are members of Federally recognized Tribes except the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
1932(a)(2)(A)(i) *Supplemental* 42 CFR 438.50(d)(3)(i)	iii.	_x_ Children under the age of 19 years, who are eligible for Security Income (SSI) under title XVI.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv.	_x_ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.
1932(a)(2)(A)(v) out-of- 42 CFR 438.50(3)(iii)	v.	_x_ Children under the age of 19 years who are in foster care or other the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi.	_x_ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) through a	*vii.*	_x_ *Children under the age of 19 years who are receiving services*

Citation	Condition or Requirement
42 CFR 438.50(3)(v)	family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

Children who receive services through Colorado's Health Care Program for Children with Special Needs.

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

____ i. *program participation,*
____ ii. special health care needs, or
_x_ iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

_x_ i. yes
____ ii. no

1932(a)(2)
exempt 42 CFR 438.50 (d)
identification)

4. Describe how the state identifies the following groups of children who are from mandatory enrollment: *(Examples: eligibility database, self-*

i. Children under 19 years of age who are eligible for SSI under title XVI;

Eligibility database.

Citation	Condition or Requirement
	ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; **Eligibility database.**
	iii. Children under 19 years of age who are in foster care or other out-of-home placement; **Eligibility database.**
	iv. Children under 19 years of age who are receiving foster care or adoption assistance. **Eligibility database.**
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* **Not applicable. Enrollment is not mandatory.**
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* **Not applicable. Enrollment is not mandatory.** i. Recipients who are also eligible for Medicare.

Citation	Condition or Requirement

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

All eligibility groups are permitted to enroll in the Primary Care Physician Program on a voluntary basis.

I. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

Citation	Condition or Requirement
	There is no passive or default enrollment for the Primary Care Physician Program. A client must actively choose to participate in the program, and selects a primary care provider upon enrollment into the program.
	ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).
	Not applicable. There is no passive or default enrollment into the Primary Care Physician Program.
	iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*
	Not applicable. There is no passive or default enrollment into the Primary Care Physician Program.
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information:
	This section is not applicable. There is no default enrollment into the Primary Care Physician Program.
	i. The state will___/will not____ use a lock-in for managed care managed care.
	ii. The time frame for recipients to choose a health plan before being auto-assigned will be:
	iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

Citation	Condition or Requirement

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _x_ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. _x_ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   _x_ This provision is not applicable to this 1932 State Plan Amendment.

4. ____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section

Citation	Condition or Requirement

1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

_x_ This provision is not applicable to this 1932 State Plan Amendment.

5. _x_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

___This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will _x_ /will not___ use lock-in for managed care.

2. The lock-in will apply for _12_ months (up to 12 months).

3. Place a check mark to affirm state compliance.

_x_ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

a. The Enrollee's provider is relocating and the new location is not reachable within a reasonable time using available and affordable modes of transportation.
b. The Enrollee is relocating and travel to the Enrollee's provider cannot be achieved within a reasonable time using available and affordable modes of transportation
c. The Enrollee's provider is no longer participating in the PCCM program.
d. The Enrollee's provider no longer wishes to see the Enrollee for the following reasons:
i. Enrollee repeatedly fails to follow medical instructions.
ii. Enrollee repeatedly fails to keep appointments.
iii. Enrollee repeatedly fails to show Medicaid Authorization Card.

Citation	Condition or Requirement

iv. Enrollee is abusive to the provider *and/or provider's staff.*

e. **If the temporary loss of eligibility has caused the Enrollee to miss the annual disenrollment opportunity, the Enrollee may disenroll upon regaining eligibility.**

f. **The provider does not, because of moral or religious objections, *cover* the service the Enrollee needs.**

g. **The Enrollee needs related services (for example, a caesarian section and a tubal ligation) to be performed at the same time; not all related services are available within the PCCM program; and the Enrollee's PCP or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk.**

h. **Enrollment into the PCCM program, or the choice of or assignment to, the provider was in error.**

i. **The Enrollee has received poor quality of care from the provider.**

j. **There is a lack of access to covered services within the program.**

k. ***There is a lack of access to providers* experienced in dealing with the Enrollee's health care needs.**

l. **Any other reasons satisfactory to the State.**

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

___The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

42 CFR 438.10(i) does not apply("Special rules: States with mandatory enrollment under state plan authority") because enrollment is voluntary under this plan.

The State is in compliance with the informational requirements of 42 CFR 438.10(e) and 42 CRF 438.10(f) and other applicable requirements of 42 CFR 438.10.

1932(a)(5)(D) L. List all services that are excluded for each model (MCO & PCCM)

Citation	Condition or Requirement
1905(t)	**All Medicaid services are included in the PCPP. All services provided by someone other than the assigned PCCM provider will need a referral from the assigned PCCM provider, except for the following (which are available directly and without referral):** **1. Emergency care.** **2. EPSDT screening examinations.** **3. Emergency and non-emergent county transportation.** **4. Anesthesiology services.** **5. Dental and vision services including refractions.** **6. Family planning services.** **7. Behavioral health services.** **8. Home and community based services.** **9. Services rendered pursuant to a child abuse diagnostic code.** **10. Obstetric care.** **11. Hospice.**
1932 (a)(1)(A)(ii)	M. Selective contracting under a 1932 state plan option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. *The state will_____/will not_____ intentionally limit the number of entities it* contracts under a 1932 state plan option. 2. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services. 3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)* 4. _x_ The selective contracting provision in not applicable to this state plan. N. *PCCM Contracts*

Citation	Condition or Requirement

1. **PCCM contracts for providers in the Primary Care Physician Program set forth all payments (except for fee-for-service reimbursements) to these PCCMs. These contracts also describe the services rendered in exchange for the payments.**

2. **The State shall submit all Primary Care Case Management contracts to CMS for review and approval.**

Citation	Condition or Requirement

SECTION 2: PRIMARY CARE PHYSICIAN PROGRAM (PCPP)

This Section has been deleted effective August 1, 2014.

Citation	Condition or Requirement

SECTION 3: COLORADO ALLIANCE FOR HEALTH AND INDEPENDENCE (CAHI)

This Section has been deleted effective January 1, 2013.

Citation	Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Colorado enrolls Medicaid beneficiaries on a **voluntary** basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

__X__ i. MCO
____ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

In the Accountable Care Collaborative (ACC) Payment Reform Program (Program), the State will contract with Rocky Mountain Health Plans (RMHP) to implement the Colorado House Bill 12-1281. The Program is comprised of a comprehensive risk-based payment for a subset of the ACC eligible population in 7 counties in RCCO region 1.

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

____ i. fee for service;

Citation	Condition or Requirement
	SECTION 3: ACC PAYMENT REFORM PROGRAM
	_X_ ii. capitation; ____ iii. a case management fee; ____ iv. a bonus/incentive payment; ____ v. a supplemental payment, or ____ vi. other. (Please provide a description below). **The State will pay RMHP a comprehensive capitation payment.**
1905(t) 42 CFR 440.168 42 CFR 438.6(c)(5)(iii)(iv)	3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met. If applicable to this state plan, place a check mark to affirm the state has met *all* of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)). ____ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered. ____ ii. Incentives will be based upon specific activities and targets. ____ iii. Incentives will be based upon a fixed period of time. ____ iv. Incentives will not be renewed automatically. ____ v. Incentives will be made available to both public and private PCCMs. ____ vi. Incentives will not be conditioned on intergovernmental transfer agreements. _X_ vii. Not applicable to this 1932 state plan amendment.
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

Citation | Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

In 2012, HB 12-1281 created a statute that required the Department to accept proposals for innovative ACC payment reform models designed to improve client outcomes while reducing costs. The Department went through an extensive public outreach process, which consisted of stakeholder meetings where drafts of the guidelines for proposal (GFP) were reviewed. The GFP outlined minimum requirements and selection criteria for the proposals. The Department ultimately selected the proposal of RMHP. RMHP collaborated with all of the provider types within its network to develop its payment reform proposal. RMHP has established an advisory group of stakeholders that will meet quarterly to monitor the Program. The State will also solicit feedback from the ACC Program Improvement Advisory Committee (PIAC) throughout the duration of the Program.

1932(a)(1)(A)

5. The state plan program will___/will not_X__ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary__X___ enrollment will be implemented in the following county/area(s):

i. county/counties (mandatory) _____

ii. county/counties (voluntary) **Mesa, Montrose, Delta, Gunnison, Pitkin, Garfield and Rio Blanco.**

iii. area/areas (mandatory)_____

iv. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

Citation	Condition or Requirement
SECTION 3: ACC PAYMENT REFORM PROGRAM	
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. __X__ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. ____ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. __X__ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.
1932(a)(1)(A 42 CFR 431.51 1905(a)(4)(C)	4. __X__ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5. __X__ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6. __X__ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7. ____ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8. __X__ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

D. Eligible groups

Citation	Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

1932(a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis.

None.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. __X__ Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*

Medicare eligible recipients who were enrolled in RMHP's PIHP and/or are in a Medicare Advantage program and reside in the ACC Payment Reform Program catchment area will be passively enrolled into the ACC Payment Reform Program. Medicare eligible recipients who opt out of the ACC Demonstration to Integrate Care for Medicare and Medicaid Eligible Beneficiaries may opt into the ACC Payment Reform Program. Beneficiaries will not be enrolled in both programs simultaneously.

1932(a)(2)(C)
when
42 CFR 438(d)(2)

ii. __X__ Indians who are members of Federally recognized Tribes except the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

1932(a)(2)(A)(i)
Supplemental
42 CFR 438.50(d)(3)(i)

iii. __X__ Children under the age of 19 years, who are eligible for Security Income (SSI) under title XVI.

Citation	Condition or Requirement
	SECTION 3: ACC PAYMENT REFORM PROGRAM
	Only children who are in this mandatory exempt group and fall into the Aid to the Needy Disabled/Aid to the Blind (AND) eligibility group will be passively enrolled into the ACC Payment Reform Program.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv. X Children under the age of 19 years who are eligible under 1902(e)(3) of the Act. **Only children who are in this mandatory exempt group and fall into the AND eligibility group will be passively enrolled into the ACC Payment Reform Program.**
1932(a)(2)(A)(v) of- 42 CFR 438.50(3)(iii)	v. X Children under the age of 19 years who are in foster care or other out- the-home placement. **Only children who are in this mandatory exempt group and fall into the AND eligibility group will be passively enrolled into the ACC Payment Reform Program.**
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. X Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E. **Only children who are in this mandatory exempt group and fall into the AND eligibility group will be passively enrolled into the ACC Payment Reform Program.**
1932(a)(2)(A)(ii) a 42 CFR 438.50(3)(v)	vii. X Children under the age of 19 years who are receiving services through family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs. **Only children who are in this mandatory exempt group and fall into the AND eligibility group will be passively enrolled into the ACC Payment Reform Program.**

Citation	Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

Children who receive services through Colorado's Health Care Program for Children with Special Needs.

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

____i. program participation,
____ii. special health care needs, or
_X_iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

__X_i. yes
____ii. no

1932(a)(2)
42 CFR 438.50 (d)

4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self identification)*

i. Children under 19 years of age who are eligible for SSI under title XVI;

Eligibility Database

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

Citation	Condition or Requirement
	SECTION 3: ACC PAYMENT REFORM PROGRAM
	Eligibility Database
	iii. Children under 19 years of age who are in foster care or other out-of-home placement;
	Eligibility Database
	iv. Children under 19 years of age who are receiving foster care or adoption assistance.
	Eligibility Database
1932(a)(2) 42 CFR 438.50(d)	5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)*
	Not applicable. Enrollment is not mandatory.
1932(a)(2) 42 CFR 438.50(d)	6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*
	i. Recipients who are also eligible for Medicare.
	Not applicable. Enrollment is not mandatory.
	ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or

Citation	Condition or Requirement
	SECTION 3: ACC PAYMENT REFORM PROGRAM
	cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act. **Not applicable. Enrollment is not mandatory.**
42 CFR 438.50	F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment **Not applicable. Enrollment is not mandatory.**
42 CFR 438.50	G. List all other eligible groups who will be permitted to enroll on a voluntary basis **The following eligibility groups will be permitted to enroll on a voluntary basis within participating counties:** **1) Old Age Pension (Age 65+)** **2) Aid to the Needy Disabled/Aid to the Blind - Supplemental Security Income without regard to age** **3) MAGI Parents/Caretakers** **4) MAGI Pregnant Women** **5) MAGI Adults** **6) Working Adults with Disabilities (Adult Buy-In)**
	H. Enrollment process.

Citation	Condition or Requirement
	SECTION 3: ACC PAYMENT REFORM PROGRAM
1932(a)(4) 42 CFR 438.50	1. Definitions i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient. ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: i. the existing provider-recipient relationship (as defined in H.1.i). **Clients enrolled in the Program have the option of selecting a Primary Care Medical Provider (PCMP), and may choose the primary care provider with whom they already have a relationship. If that provider is not part of the Program, RMHP will request that the provider enroll.** ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii). **RMHP works with the State to recruit providers that have traditionally served Medicaid recipients to be a part of the Program. These providers have been involved as stakeholders since program planning began.** iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

Citation	Condition or Requirement
	SECTION 3: ACC PAYMENT REFORM PROGRAM
	Enrollment is voluntary, clients may choose among available MCOs and PCCMs in their geographic region, there is no cap on enrollment into any MCO or PCCM in the 7 counties so there is no need to monitor an equitable distribution. A list of the available options is included in the enrollment letter and packet sent to Medicaid clients who are passively enrolled into the Program.
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information:
	i. The state will X /will not ___ use a lock-in for managed care. **Clients are locked into the ACC Payment Reform Program, but are not locked into specific providers within the Program network.**
	ii. The time frame for recipients to choose a health plan before being auto-assigned will be: **Clients are notified of the State's intent to enroll them into the program at least 30 days before they are enrolled. After the date of effective enrollment, the client has another 90 days to disenroll. Thus, all clients have a total of 120 days to disenroll before they are locked in to the program.** **The initial lock in period starts 90 days after the effective enrollment date and lasts until the beginning of their birth month. The subsequent lock in period starts at the beginning of the client's birth month and lasts for 12 months. An open enrollment period begins 60 days prior to the clients' birth month each year. If the client disenrolls during the open enrollment period, the disenrollment will be effective at the beginning of their birth month.**

Citation	Condition or Requirement
	SECTION 3: ACC PAYMENT REFORM PROGRAM

The notification letter also describes other options available, including managed care plans, the fee-for-service option, and any other available program.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

The State's enrollment broker sends the Medicaid client a letter notifying them of the State's intent to enroll them into the Program.

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

The letter sent by the State's enrollment broker to notify a client of the State's intent to enroll the client in the Program also includes instructions for disenrolling within the first 90 days of the client's enrollment into the program.

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

The Program will enroll clients with the appropriate eligibility category and who live in a participating county. The clients are currently in the ACC, in RMHP's PIHP (which is sun setting) or are receiving fee-for-service Medicaid. Enrollment in the Program will not affect clients passively enrolled into other managed care plans. Clients in the participating counties and in the applicable eligibility categories will be enrolled in the Program instead of the standard ACC.

Citation | Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

The State monitors rates of enrollment through monthly reports generated by the enrollment broker.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _X_ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. __X__ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   _X_ This provision is not applicable to this 1932 State Plan Amendment.

4. ____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   _X_ This provision is not applicable to this 1932 State Plan Amendment.

Citation | Condition or Requirement

SECTION 3: ACC PAYMENT REFORM PROGRAM

5. __X__ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

___This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will__X__/will not___ use lock-in for managed care.

2. The lock-in will apply for __**up to12**__ months (up to 12 months).

3. Place a check mark to affirm state compliance.

__X__The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

   a. **If the temporary loss of eligibility has caused a client to miss the annual disenrollment opportunity, the client may disenroll upon regaining eligibility.**
   b. **Enrollment into the Program, or the choice of or assignment to the provider, was in error.**
   c. **There is a lack of access to covered services within the program.**
   d. **There is a lack of access to providers experienced in dealing with the client's health care needs.**
   e. **Any other reasons satisfactory to the State.**

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50

____The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs

Citation		Condition or Requirement
SECTION 3: ACC PAYMENT REFORM PROGRAM		
42 CFR 438.10		operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.) **42 CFR 438.10(i) does not apply ("Special rules: States with mandatory enrollment under state plan authority") because enrollment is voluntary under this plan.** **The State is in compliance with the informational requirements of 42 CFR 438.10(e) and 42 CRF 438.10(f) and other applicable requirements of 42 CFR 438.10.**
1932(a)(5)(D) 1905(t)	L.	List all services that are excluded for each model (MCO & PCCM) **All services and benefits including drugs covered in the state plan are included in the MCO program, either as part of the capitation payment or as wrap-around fee-for-service payments.**
1932 (a)(1)(A)(ii)	M.	Selective contracting under a 1932 state plan option To respond to items #1 and #2, place a check mark. The third item requires a brief narrative. 1. The state will__X___/will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option. 2. __X___ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services. 3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)* **The State limits the number of contracted entities based upon the competitive selection process established in State House Bill 12-1281. The criteria for selection were extensive, and were included in the GFP.**

Citation	Condition or Requirement
	SECTION 3: ACC PAYMENT REFORM PROGRAM

4. ____ The selective contracting provision in not applicable to this state plan.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS-10120 (exp. 01/31/2008)

Citation	Condition or Requirement

SECTION 3: DEMONSTRATION TO INTEGRATE CARE FOR MEDICARE AND MEDICAID ELIGIBLE CLIENTS

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Colorado enrolls Medicaid beneficiaries on a voluntary basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
_x_ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
____ iii. Both

The purpose of this initiative is to establish a Federal-State partnership between the Centers for Medicare & Medicaid Services (CMS) and the State of Colorado (State), Department of Health Care Policy and Financing (Department), to implement the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees (Demonstration), a Managed Fee-for-Service (MFFS) Financial Alignment Model. The Demonstration will coordinate services across Medicare and Medicaid and achieve cost savings for the Federal and the State government. CMS plans to begin this MFFS Financial Alignment Model Demonstration on July 1, 2014, and continue until December 31, 2017, unless terminated or extended pursuant to the terms and conditions of the Final Demonstration Agreement. Key objectives of the Demonstration are to improve beneficiary experience in accessing care, promote person-centered planning, promote independence in the community, improve quality of care, assist beneficiaries in getting the right

Citation	Condition or Requirement

care at the right time and place, reduce health disparities, improve transitions among care settings, and achieve cost savings for the Federal and the State government through improvements in health and functional outcomes.

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

_x_ i. fee for service;
____ ii. capitation;
_x_ iii. a case management fee;
____ iv. a bonus/incentive payment;
____ v. a supplemental payment, or
____ vi. other. (Please provide a description below).

1905(t)
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, incentive payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met *all* of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

____ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

____ ii. Incentives will be based upon specific activities and targets.

____ iii. Incentives will be based upon a fixed period of time.

____ iv. Incentives will not be renewed automatically.

____ v. Incentives will be made available to both public and private PCCMs.

____ vi. Incentives will not be conditioned on intergovernmental transfer agreements.

_x_ vii. Not applicable to this 1932 state plan amendment.

CFR 438.50(b)(4)

4. *Describe* the public process utilized for both the design of the program and its

Citation	Condition or Requirement
	initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)* **The Department engaged a wide variety of stakeholders and partners throughout the initial stages of proposal development from June 2011 through May 2012. The collaborative process to solicit input and provide opportunities for feedback included six statewide stakeholder meetings with toll-free call-in options; five recurring workgroups devoted to Communication (Outreach and Information), Care Coordination, Behavioral Health, Developmental Disabilities, and Financing Strategies and Quality Medical Outcomes; nine area stakeholder meetings across the state; 58 presentations to and conversations with individual stakeholders and specific organizations; Tribal Consultation; a dedicated web page on the Department's Web site; and a toll-free question/comment hot line. The Department continued its engagement with stakeholders through focused interviews with Medicare-Medicaid enrollees and focus groups for caregivers.** **As part of the Demonstration, CMS and the State require mechanisms to ensure meaningful beneficiary input processes and the involvement of beneficiaries in planning and process improvements. In addition, the State provides avenues for ongoing beneficiary input into the Demonstration model, including beneficiary participation through the Colorado Medicare-Medicaid Enrollees Advisory Subcommittee, the ACC Program Improvement Advisory Committee and its standing subcommittees.** **The State is developing input processes and systems to monitor and measure the level of care provided to Medicare-Medicaid enrollees in the Demonstration. Moreover, the State the beneficiary rights and protections alliance may provide additional beneficiary input and feedback throughout the Demonstration's planning processes; implementation, and operation. All activities needed to fulfill the Department's commitment to collaborative process, multi-perspective evaluation, and continuous improvement will continue after implementation.**
1932(a)(1)(A)	5. The state plan program will ___/will not _x_ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory_____/ voluntary____ enrollment will be implemented in the following county/area(s): i. county/counties (mandatory) _____

Citation	Condition or Requirement

ii. county/counties (voluntary)_____

iii. area/areas (mandatory)_____

iv. area/areas (voluntary)_____

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. ___ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. x The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. x The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

1932(a)(1)(A
42 CFR 431.51
1905(a)(4)(C)

4. x The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

1932(a)(1)(A)
42 CFR 438
42 CFR 438.50(c)(4)
1903(m)

5. x The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

1932(a)(1)(A)
42 CFR 438.6(c)
42 CFR 438.50(c)(6)

6. ___ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.

1932(a)(1)(A)
42 CFR 447.362
42 CFR 438.50(c)(6)

7. x The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.

45 CFR 74.40

8. x The state assures that all applicable requirements of 45 CFR 92.36 for

Citation	Condition or Requirement

procurement of contracts will be met.

D. Eligible groups

1932(a)(1)(A)(i)

1. *List all eligible groups that will be enrolled on a mandatory basis.*

None.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1)

i. _x_ Recipients who are also eligible for Medicare.
Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*

1932(a)(2)(C)
42 CFR 438(d)(2)

ii. _x_ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to *title V of the Indian Health Care* Improvement Act.

Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.

1932(a)(2)(A)(i)
42 CFR 438.50(d)(3)(i)

iii. _x_ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

Citation		Condition or Requirement
		Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.
1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(ii)	iv.	_x__Children under the age of 19 years who are eligible under 1902(e)(3) of the Act. **Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.**
1932(a)(2)(A)(v) *42 CFR 438.50(3)(iii)*	v.	_x__Children under the age of 19 years who are in foster care or other out-of-the-home placement. **Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.**
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi.	_x__Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E. **Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.**
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii.	_x__Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs. **Recipients who are eligible for the Colorado Demonstration to Integrate Care for Medicare-Medicaid Enrollees will be voluntarily enrolled in the ACC. A demonstration eligible recipient that opts out of the demonstration will be disenrolled from the demonstration and the ACC.**

Citation	Condition or Requirement

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

Children who receive services through Colorado's Health Care Program for Children with Special Needs.

1932(a)(2)
42 CFR 438.50(d)

2. Place a check mark to affirm if the state's definition of title V children is determined by:

____i. program participation,
____ii. special health care needs, or
_x_iii. both

1932(a)(2)
42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

_x_i. yes
____ii. no

1932(a)(2)
42 CFR 438.50 (d)

4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)*

i. Children under 19 years of age who are eligible for SSI under title XVI:

Eligibility database.

ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act;

Eligibility database.

iii. Children under 19 years of age who are in foster care or other out-of-home placement:

Eligibility database.

Citation		Condition or Requirement
		iv. Children under 19 years of age who are receiving foster care or adoption assistance. **Eligibility database.**
1932(a)(2) 42 CFR 438.50(d)	5.	Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)* **Not applicable. Enrollment is not mandatory.**
1932(a)(2) 42 CFR 438.50(d)	6.	Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)* **Not applicable. Enrollment is not mandatory.** i. Recipients who are also eligible for Medicare. ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.
42 CFR 438.50	F.	List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment **Not applicable. Enrollment is not mandatory.**
42 CFR 438.50	G.	List all other eligible groups who will be permitted to enroll on a voluntary basis **In accordance with the signed and approved MOU between CMS and the State, individuals eligible for this Demonstration are those meeting the following criteria:** **1. are enrolled in Medicare Parts A and B and eligible for Part D;** **2. receive physical health Medicaid benefits under Fee-for-Service (FFS) arrangements;**

Citation	Condition or Requirement

3. **receive behavioral health Medicaid benefits under capitated arrangements; and**
4. **have no other private or public health insurance; and are a resident of the State.**

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932(a)(4)
42 CFR 438.50

2. State process for enrollment by default.

Describe how the state's default enrollment process will preserve:

i. the existing provider-recipient relationship (as defined in H.1.i).

Clients enrolled in the program have the option of selecting a Primary Care Medical Provider (PCMP), and may choose the primary care provider they already have a relationship with. If that provider is not part of the ACC program, the PCCM entity (Regional Care Collaborative Organization) will request that the provider enroll. The State will initially identify a PCMP based on which provider was the main source of primary care for the client during the previous year.

ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii).

The Regional Care Collaborative Organizations work with the State to recruit providers that have traditionally served Medicare-Medicaid beneficiaries to be a part of the ACC program. These providers have been involved as stakeholders since program planning began.

iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4));

Citation	Condition or Requirement
	and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity)* **The State's enrollment process does not preserve the equitable distribution of Medicare-Medicaid beneficiaries among PCMPs because enrollment is voluntary. Clients may choose from among available MCOs and PCCMs in their geographic areas. A list of available options is included in the enrollment letter and packet sent to Medicare-Medicaid beneficiaries who are passively enrolled into the program.**
1932(a)(4) 42 CFR 438.50	3. As part of the state's discussion on the default enrollment process, include the following information:
	i. The state will ___/will not __X__ use a lock-in for managed care managed care.
	ii. The time frame for recipients to choose a health plan before being auto-assigned will be: **Medicare-Medicaid beneficiaries are notified of the State's intent to enroll them into the program 30 days before they are enrolled. This letter also describes other options available, including managed care plans, the fee-for-service option, and any other available program.**
	iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)* **The State's enrollment broker sends the Medicare-Medicaid beneficiary a letter notifying them of the State's intent to enroll them into the program.**
	iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)* **The letter sent by the State's enrollment broker to notify a Medicare-Medicaid beneficiary of the State's intent to enroll the beneficiary in the ACC program also includes instructions for disenrolling.**

Citation	Condition or Requirement

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

Enrollment is based on geographic service areas. The program enrolls full benefit Medicare- Medicaid beneficiaries receiving fee-for-service Medicaid and will not affect the number of clients passively enrolled into other managed care plans.

vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

The State monitors rates of enrollment through monthly reports generated by the enrollment broker.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. _x_ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. _x_ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   _x_ This provision is not applicable to this 1932 State Plan Amendment.

4. ____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   _x_ This provision is not applicable to this 1932 State Plan Amendment.

Citation		Condition or Requirement

5. _x_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

___This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.50

J. Disenrollment

1. The state will__/will not_x_ use lock-in for managed care.

2. The lock-in will apply for __ months (up to 12 months).

3. Place a check mark to affirm state compliance.

_x_ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

____The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

42 CFR 438.10(i) does not apply("Special rules: States with mandatory enrollment under state plan authority") because enrollment is voluntary under this plan.

The State is in compliance with the informational requirements of 42 CFR 438.10(e) and 42 CRF 438.10(f) and other applicable requirements of 42 CFR 438.10.

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

All Medicaid services are included in the program.

1932 (a)(1)(A)(ii)

M. Selective contracting under a 1932 state plan option

Citation	Condition or Requirement

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will__x__/will not_____ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. _x___ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*
The State limits the number of PCCM entities that serve as Regional Care Collaborative Organizations (RCCOs). To maximize collaboration, the program is designed to have one RCCO in each area of the State. RCCO selection was done as a competitive procurement. The criteria for selection are extensive, and are included in the Request for Proposals.

4. ___ The selective contracting provision in not applicable to this state plan.

N. PCCM Contracts

1. **PCCM contracts for Regional Care Collaborative Organizations and Primary Care Medical Providers set forth all payments (except for fee-for-service reimbursements) to these PCCM entities, including the per-member-per-month fee and any incentive payments. These contracts also describe the services rendered in exchange for the payments.**

2. **The State shall submit all PCCM provider contracts to CMS for review and approval**

Citation	Condition or Requirement

SECTION 5: ACC: ACCESS KAISER PROGRAM

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Colorado enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

The State of Colorado enrolls Medicaid beneficiaries on a voluntary basis into this MCO program under section 1932(a)(1)(A) of the Act.

This authority may *not* be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs). nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place check mark to affirm such compliance.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ☒MCO
   a. ☒Capitation

2. ☐PCCM (individual practitioners)
   a. ☐ Case management fee
   b. ☐ Bonus/incentive payments
   c. ☐ Other (please explain below)

3. ☐PCCM (entity based)
   a. ☐ Case management fee

Citation | Condition or Requirement

SECTION 5: ACC: ACCESS KAISER PROGRAM

b. ☐ Bonus/incentive payments
c. ☐ Other (please explain below)

For states that elect to pay a PCCM a bonus/incentive payment as indicated in B.2.b. or B.3.b, place a check mark to affirm the state has met ***all*** of the following conditions (which are representative of the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

☐a. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

☐b. Incentives will be based upon a fixed period of time.

☐c. Incentives will not be renewed automatically.

☐d. Incentives will be made available to both public and private PCCMs.

☐e. Incentives will not be conditioned on intergovernmental transfer agreements.

☐f. Incentives will be based upon specific activities and targets.

CFR 438.50(b)(4)

C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

Since 2012, the Department has been engaging stakeholders in conversations about payment reform initiatives to be implemented within the Accountable Care Collaborative (ACC) Program. This is the second payment initiative. Specific to this initiative, the Department engaged its ACC Program Improvement Advisory Committee (PIAC) and the Provider and Community

Citation	Condition or Requirement
	SECTION 5: ACC: ACCESS KAISER PROGRAM
	Issues sub-committee; consulted with tribal governments; and served Public Notice through the Colorado Register. Ongoing stakeholder engagement and public involvement will occur through the existing ACC PIAC stakeholder structure and also through a public committee the MCO is contractually required to develop and manage.
	D. State Assurances and Compliance with the Statute and Regulations.
	If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. ☒The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. ☐The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. ☒The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring Beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4. ☒The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A)	5. ☒The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438 1903(m)	6. ☒The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.

Citation	Condition or Requirement
SECTION 5: ACC: ACCESS KAISER PROGRAM	
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	7. ☒The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) CFR 447.362 42 CFR 438.50(c)(6)	8. ☐The state assures that all applicable requirements of 42 CFR 447.362 for 42 payments under any non-risk contracts will be met.
45 CFR 92.36	9. ☒The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

Citation | Condition or Requirement

SECTION 5: ACC: ACCESS KAISER PROGRAM

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area

1. **Included Populations.** Please check which eligibility populations are included. if they are enrolled on a mandatory (M) or voluntary (V) basis, and the geographic scope of enrollment. Under the geography column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions.

Population	M	Geographic Area	V	Geographic Area	Excluded
Section 1931 Children & Related Populations – 1905(a)(i)			X	Adams, Arapahoe, Douglas counties	
Section 1931 Adults & Related Populations1905(a)(ii)			X	Adams, Arapahoe, Douglas counties	
Low-Income Adult Group			X	Adams, Arapahoe, Douglas counties	
Former Foster Care Children under age 21			X	Adams, Arapahoe, Douglas counties	
Former Foster Care Children age 21-25			X	Adams, Arapahoe, Douglas counties	
Section 1925 Transitional Medicaid age 21 and older			X	Adams, Arapahoe, Douglas counties	
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)			X	Adams, Arapahoe, Douglas counties	
Poverty Level Pregnant Women – 1905(a)(viii)			X	Adams, Arapahoe, Douglas counties	
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)			X	Adams, Arapahoe, Douglas counties	
SSI and SSI related Disabled children under age 18			X	Adams, Arapahoe, Douglas counties	
SSI and SSI related Disabled adults age 18 and older – 1905(a)(v)			X	Adams, Arapahoe, Douglas counties	

Citation | Condition or Requirement

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Population	M	Geographic Area	V	Geographic Area	Excluded
SSI and SSI Related Aged Populations age 65 or older-1905(a)(iii)			X	Adams, Arapahoe, Douglas counties	
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)			X	Adams, Arapahoe, Douglas counties	
Recipients Eligible for Medicare			X	Adams, Arapahoe, Douglas counties	
American Indian/Alaskan Natives			X	Adams, Arapahoe, Douglas counties	
Children under 19 who are eligible for SSI			X	Adams, Arapahoe, Douglas counties	
Children under 19 who are eligible under Section 1902(e)(3)			X	Adams, Arapahoe, Douglas counties	
Children under 19 in foster care or other in-home placement			X	Adams, Arapahoe, Douglas counties	
Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v)			X	Adams, Arapahoe, Douglas counties	
Other					

2. **Excluded Groups.** Within the populations identified above as Mandatory or Voluntary, there may be certain groups of individuals who are excluded from the managed care program. Please indicate if any of the following groups are excluded from participating in the program:

☐ Other Insurance--Medicaid beneficiaries who have other health insurance.

☐ Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

Citation | Condition or Requirement

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☒ Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program
Recipients enrolled in any physical health managed care program are excluded from this program. However, all recipients should simultaneously be enrolled in a BHO and this program. Enrollment with a BHO is not grounds for exclusion.

☐ Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☐ Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

☒ Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.

☒ Other (Please define):
Recipients enrolled in Medicare are excluded from this program.

1932(a)(4) F. Enrollment Process.

1. Definitions.

   a. Auto Assignment- assignment of a beneficiary to a health plan when the beneficiary has not had an opportunity to select their health plan.

   b. Default Assignment- assignment of a beneficiary to a health plan when the beneficiary has had an opportunity to select their health plan.

2. Please describe how the state effectuates the enrollment process. Select an enrollment methodology from the following options and describe the elements listed beneath it:

   a. ☐ The applicant is permitted to select a health plan at the time of application.

      i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

Citation | Condition or Requirement

SECTION 5: ACC: ACCESS KAISER PROGRAM

ii. What action the state takes if the applicant does not indicate a plan selection on the application.

iii. If action includes making a default assignment, describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

iv. The state's process for notifying the beneficiary of the default assignment. (Example: *state generated correspondence.*)

b. ☒ The beneficiary has an active choice period following the eligibility determination.

i. How the beneficiary is notified of their initial choice period, including its duration.
Clients are enrolled in the program through a passive enrollment process. The State's enrollment broker sends the Medicaid client an enrollment letter at least thirty (30) days prior to their enrollment date. The letter informs the client that they can opt-out of this program for an additional ninety (90) days after their enrollment date.

ii. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).
The beneficiaries will receive a member handbook within thirty (30) days of receiving the enrollment notice. The member handbook and the enrollment letter materials cover all of the requirements in 42 CFR 438.10(e).

iii. Describe the algorithm used for default assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).
Default assignment will occur for the initial enrollment for this program. This default assignment process will function as a passive enrollment process in which all beneficiaries will have the ability to opt-out for at least thirty (30) days prior to enrollment and for another sixty (60) days after enrollment. All beneficiaries currently enrolled in the Accountable Care Collaborative (ACC) program in Adams, Arapahoe, and Douglas counties that are attributed to Kaiser Permanente as their primary care medical provider will be disenrolled from that program and enrolled into the ACC: Access Kaiser

Citation	Condition or Requirement

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Program. This process will ensure existing provider-beneficiary relationships are preserved as required in 42 CFR 438.50(f).

After the one-time initial enrollment, beneficiaries will only be enrolled if they meet an appropriate eligibility category, live in a participating county, and proactively call the State contracted enrollment broker to opt-in to this program.

iv. The state's process for notifying the beneficiary of the default assignment. **The State's enrollment broker sends the Medicaid client a letter notifying them of the State's intent to enroll them into the program**

c. ☐ The beneficiary is auto-assigned to a health plan immediately upon being determined eligible.

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

ii. The state's process for notifying the beneficiary of the auto-assignment. (*Example: state generated correspondence.*)

iii. Describe the algorithm used for auto-assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

1932(a)(4)
42 CFR 438.50

3. State assurances on the enrollment process.

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

a. ☒The state assures it has an enrollment system that allows Beneficiaries who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

b. ☒The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid Beneficiaries enrolled in either an MCO or PCCM model will have a choice of at

Citation | Condition or Requirement

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least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

c. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

☒This provision is not applicable to this 1932 State Plan Amendment.
There are no rural counties in this program.

d. ☒ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

☐This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.56

G. Disenrollment.

1. The state will☒/will not☐ limit disenrollment for managed care.

2. The disenrollment limitation will apply for twelve months (up to 12 months).

Clients may disenroll from this program during the annual open enrollment period. The annual open enrollment period is the two months prior to the clients birth month.

3. ☒The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe the state's process for notifying the Medicaid Beneficiaries of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*
The letter sent by the State's enrollment broker to notify a client of the State's intent to enroll the client in the program also includes instructions for disenrolling within the first ninety (90) days of the client's enrollment into the program.

5. Describe any additional circumstances of "cause" for disenrollment (if any).

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	SECTION 5: ACC: ACCESS KAISER PROGRAM

a) If the temporary loss of eligibility has caused a beneficiary to miss the annual disenrollment opportunity, the beneficiary may disenroll within sixty (60) days of regaining eligibility and enrollment into the program.
b) Enrollment into the program, or the choice of or assignment to the provider, was in error.
c) There is a lack of access to covered services within the program.
d) There is a lack of access to providers experienced in dealing with the client's health care needs.
e) Any other reasons satisfactory to the State.

H. Information Requirements for Beneficiaries

1932(a)(5)(c)
42 CFR 438.50
42 CFR 438.10

☒The state assures that its state plan program is in compliance with 42 CFR 438.10(c) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)(b)

I. List all benefits for which the MCO is responsible.
The benefits are defined at the procedure code level and are listed in the Contract between the State and MCO.

1903(m)
1905(t)(3)

1932(a)(5)(D)(b)(4)
42 CFR 438.228

J. ☒The state assures that each managed care organization has established an internal grievance procedure for enrollees.

1932(a)(5)(D)(b)(5)

K. Describe how the state has assured adequate capacity and services.
The State has assured adequate capacity and services by assessing the current provider network capacity in the region and the number of currently attributed beneficiaries. These will be the same beneficiaries enrolled in this program and they will stay with their current provider. Also, the State contract with the MCO requires the MCO to maintain adequate capacity and services.

42 CFR 438.206
42 CFR 438.207

1932(a)(5)(D)(c)(1)(A)
42 CFR 438.240

L. ☒The state assures that a quality assessment and improvement strategy has been developed and implemented.

Citation	Condition or Requirement

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1932(a)(5)(D)(c)(2)(A)
42 CFR 438.350

M. ☒The state assures that an external independent review conducted by a qualified independent entity will be performed yearly.

1932 (a)(1)(A)(ii)

N. Selective Contracting Under a 1932 State Plan Option

To respond to items #1 and #2, place a check mark. The third item requires a.brief narrative.

1. The state will☒/will not☐ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. ☒The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

   The State will only contract with the Region 3 Regional Care Collaborative Organization, Colorado Access, through a Provider Services contract.

4. ☐The selective contracting provision in not applicable to this state plan.

Citation | Condition or Requirement

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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

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